IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

UNITED STATES OF AMERICA, *Plaintiff,* v. STATE OF MISSISSIPPI, *Defendant.*	CIVIL ACTION NO. 3:16-CV-00622-CWR-FKB

TRIAL STIPULATIONS

The Parties stipulate as follows:

1. The State of Mississippi ("State") is a public entity within the meaning of the ADA and is therefore subject to Title II of the ADA and its implementing regulations.
2. The State administers and controls the State's mental health system through the Division of Medicaid ("DOM"), which pays for mental health services for Medicaid-enrolled adults with mental illness, and through the Department of Mental Health ("DMH"), which is the state agency responsible for providing mental health services to the eligible citizens of Mississippi.
3. The State's fiscal year begins on July 1 and ends on the following June 30.
4. The State refers to its fiscal years by the calendar year in which the fiscal year ends. For example, Fiscal Year ("FY") 18 ended on June 30, 2018.

The Department of Mental Health

5. The State offers community-based mental health services primarily through fourteen regional community mental health centers ("CMHCs"). DMH is responsible for certifying, monitoring, and assisting the CMHCs.
6. The CMHCs are required to offer certain mental health services, including psychiatric services, individual and group therapy, community-based support services, crisis services, and peer support services. Some CMHCs also offer more intensive services, like Programs of Assertive Community Treatment (PACT), supported employment, and supported housing.
7. DMH certifies each CMHC prior to its selection as the designated provider, promulgates operational standards for all CMHCs, conducts reviews of CMHC operations, awards grant funds to support specific community services, and requires financial and performance reporting.

8. DMH drafts and updates its Operational Standards, which set definitions for services, eligibility for those services, staff training and qualification requirements, and certification standards.
9. DMH funds and operates four State Hospitals: Mississippi State Hospital in Whitfield, MS ("MSH"), East Mississippi State Hospital, in Meridian, MS ("EMSH"), North Mississippi State Hospital, in Tupelo ("NMSH"), MS, and South Mississippi State Hospital, in Purvis, MS ("SMSH").[1]
10. The State Hospitals are institutions under the meaning of 42 U.S.C. § 1997(1).
11. The State Hospitals are institutional, segregated settings. Stipulation No 11 does not include the Kemper County Group Homes operated by East Mississippi State Hospital. Also, this stipulation does not address whether treatment in the State Hospitals is appropriate for individuals with disabilities or any individual in particular, or whether any State Hospital is or was the least restrictive setting or environment for individuals with disabilities or any individual in particular, or whether a segregated setting in any State Hospital was unnecessary for individuals with disabilities or any individual in particular.
12. All patients at the State Hospitals are involuntarily committed there.
13. Individuals admitted to or at serious risk of entry into State Hospitals have mental illnesses, such as schizophrenia, bipolar disorder, depression, and others, that substantially limit one or more major life activities, including personal care, working, concentrating, thinking, and sleeping. They are therefore persons with disabilities for purposes of the ADA.
14. Integrated, community-based services can enhance and support recovery from mental illness.

Mississippi State Hospital

15. The Mississippi State Hospital, the largest of the State Hospitals, is located on a 350-acre campus in Whitfield, Mississippi and was established at Whitfield in 1885.
16. In 2011 MSH had 154 beds in the receiving unit, which provides acute care.
17. In 2011 MSH had 158 beds in the continued treatment unit, which provides long term care.
18. In FY11 MSH's receiving unit served 1,556 individuals.
19. In FY11 MSH's continued treatment unit served 258 individuals.
20. In 2011 MSH's average daily census for the receiving unit was 129.92 individuals.
21. In 2011 MSH's average daily census for the continued treatment unit was 130 individuals.
22. In 2011 the average length of stay in MSH's receiving unit was 33.05 days.
23. In 2012 MSH had 154 beds in the receiving unit.
24. In 2012 MSH had 96 beds in the continued treatment unit.
25. In FY12 MSH's receiving unit served 1,615 individuals.

[1] As used in these Stipulations, unless otherwise stated, reference to "State Hospitals" or a particular State Hospital does not include the forensic unit at Mississippi State Hospital, nursing facilities at the State Hospitals, and adolescent or chemical dependency units.

26. In FY12 MSH's continued treatment unit served 195 individuals.
27. In 2012 MSH's average daily census for the receiving unit was 136.04 individuals.
28. In 2012 MSH's average daily census for the continued treatment unit was 80.57 individuals.
29. In 2012 the average length of stay in MSH's receiving unit was 35.56 days.
30. In 2013 MSH had 154 beds in the receiving unit.
31. In 2013 MSH had 99 beds in the continued treatment unit.
32. In FY13 MSH's receiving unit served 1,404 individuals.
33. In FY13 MSH's continued treatment unit served 134 individuals.
34. In 2013 MSH's average daily census for the receiving unit was 143.22 individuals.
35. In 2013 MSH's average daily census for the continued treatment unit was 73.39 individuals.
36. In 2013 the average length of stay in MSH's receiving unit was 41.45 days.
37. In 2014 MSH had 154 beds in the receiving unit.
38. In 2014 MSH had 101 beds in the continued treatment unit.
39. In FY14 MSH's receiving unit served 1,174 individuals.
40. In FY14 MSH's continued treatment unit served 119 individuals.
41. In 2014 MSH's average daily census for the receiving unit was 146.54 individuals.
42. In 2014 MSH's average daily census for the continued treatment unit was 72.18 individuals.
43. In 2014 the average length of stay in MSH's receiving unit was 46.27 days.
44. In 2015 MSH had 146 beds in the receiving unit.
45. In 2015 MSH had 91 beds in the continued treatment unit.
46. In FY15 MSH's receiving unit served 1,123 individuals.
47. In FY15 MSH's continued treatment unit served 101 individuals.
48. In 2015 MSH's average daily census for the receiving unit was 131.55 individuals.
49. In 2015 MSH's average daily census for the continued treatment unit was 77.31 individuals.
50. In 2015 the average length of stay in MSH's receiving unit was 43.77 days.
51. In FY15 MSH's total expenditures were $125,666,672.
52. In 2016 MSH had 139 beds in the receiving unit.
53. In 2016 MSH had 94 beds in the continued treatment unit.
54. In FY16 MSH's receiving unit served 1,045 individuals.
55. In FY16 MSH's continued treatment unit served 120 individuals.
56. In 2016 MSH's average daily census for the receiving unit was 132.92 individuals.
57. In 2016 MSH's average daily census for the continued treatment unit was 86.81 individuals.
58. In 2016 the average length of stay in MSH's receiving unit was 45.42 days.
59. In FY16 MSH's total expenditures were $127,635,233.
60. In 2017 MSH had 142 beds in the receiving unit.
61. In 2017 MSH had 95 beds in the continued treatment unit.
62. In FY17 MSH's receiving unit served 1,142 individuals.
63. In FY17 MSH's continued treatment unit served 123 individuals.

64. In 2017 MSH's average daily census for the receiving unit was 131.94 individuals.
65. In 2017 MSH's average daily census for the continued treatment unit was 85.08 individuals.
66. In 2017 the average length of stay in MSH's receiving unit was 41.41 days.
67. In FY17 MSH's total expenditures were $116,269,117.
68. In 2018 MSH had 138 beds in the receiving unit.
69. In 2018 MSH had 92 beds in the continued treatment unit.
70. In FY18 MSH's receiving unit served 1,030 individuals.
71. In FY18 MSH's continued treatment unit served 100 individuals.
72. In 2018 MSH's average daily census for the receiving unit was 119.79 individuals.
73. In 2018 MSH's average daily census for the continued treatment unit was 72.27 individuals.
74. In 2018 the average length of stay in MSH's receiving unit was 42.87 days.

East Mississippi State Hospital

75. The East Mississippi State Hospital, located in Meridian, is the second largest of the State Hospitals and was founded in 1882.
76. Mississippi recently built new a new receiving unit, laundry facility, and dietary facility at EMSH. http://www.emsh.ms.gov/index_files/constructionv3.html
77. In 2011 EMSH had 234 beds.[2]
78. In FY11 EMSH served 2,062 individuals.
79. In FY11 EMSH's average daily census was 211 individuals.
80. In FY11 EMSH's average length of stay was 118 days.
81. In FY11 EMSH's total expenditures were $63,442,331.
82. In 2012 EMSH had 168 beds.
83. In FY12 EMSH served 762 individuals.
84. In FY12 EMSH's average daily census was 144 individuals.
85. In FY12 EMSH's average length of stay was 61 days.
86. In FY12 EMSH's total expenditures were $63,449,031.
87. In 2013 EMSH had 125 beds.
88. In FY13 EMSH served 702 individuals.
89. In FY13 EMSH's average daily census was 102 individuals.
90. In FY13 EMSH's average length of stay was 32 days.
91. In FY13 EMSH's total expenditures were $60,015,632.
92. In 2014 EMSH had 100 beds.
93. In FY14 EMSH served 694 individuals.
94. In FY14 EMSH's average daily census was 95 individuals.
95. In FY14 EMSH's average length of stay was 32 days.
96. In FY14 EMSH's total expenditures were $56,589,808.
97. In 2015 EMSH had 100 beds.

[2] Consistent with footnote 1 above, EMSH beds in these stipulations refer only to the adult psychiatric beds at EMSH. Similarly, the number served, average daily census, and length of stay each relate to individuals served in adult psychiatric beds.

98. In FY15 EMSH served 569 individuals.
99. In FY15 EMSH's average daily census was 97 individuals.
100. In FY15 EMSH's average length of stay was 38 days.
101. In FY15 EMSH's total expenditures were $59,018,825.
102. In 2016 EMSH had 100 beds.
103. In FY16 EMSH served 518 individuals.
104. In FY16 EMSH's average daily census was 94 individuals.
105. In FY16 EMSH's average length of stay was 42 days.
106. In FY16 EMSH's total expenditures were $58,977,478.
107. In 2017 EMSH had 100 beds.
108. In FY17 EMSH served 551 individuals.
109. In FY17 EMSH's average daily census was 95 individuals.
110. In FY17 EMSH's average length of stay was 42 days.
111. In FY17 EMSH's total expenditures were $57,534,933.
112. In 2018 EMSH had 108 beds.
113. In FY18 EMSH served 591 individuals.
114. In FY18 EMSH's average length of stay was 43 days.

North Mississippi State Hospital

115. The North Mississippi State Hospital opened in Tupelo in 1999.
116. In FY11 NMSH had 50 beds.
117. In FY11 NMSH served 575 individuals.
118. In 2011 NMSH's average daily census was 49 individuals.
119. In 2011 NMSH's average length of stay was 36 days.
120. In FY11 NMSH's total expenditures were $8,140,112.
121. In FY12 NMSH had 50 beds.
122. In FY12 NMSH served 608 individuals.
123. In 2012 NMSH's average daily census was 46 individuals.
124. In 2012 NMSH's average length of stay was 30 days.
125. In FY13 NMSH had 50 beds.
126. In FY13 NMSH served 560 individuals.
127. In 2013 NMSH's average daily census was 46 individuals.
128. In 2013 NMSH's average length of stay was 32 days.
129. In FY14 NMSH had 50 beds.
130. In FY14 NMSH served 520 individuals.
131. In 2014 NMSH's average daily census was 43 individuals.
132. In 2014 NMSH's average length of stay was 34 days.
133. In FY15 NMSH had 50 beds.
134. In FY15 NMSH served 574 individuals.
135. In 2015 NMSH's average daily census was 45 individuals.
136. In 2015 NMSH's average length of stay was 31 days.
137. In FY15 NMSH's total expenditures were $8,612,054.
138. In FY16 NMSH had 50 beds.
139. In FY16 NMSH served 629 individuals.

140. In 2016 NMSH's average daily census was 46 individuals.
141. In 2016 NMSH's average length of stay was 29 days.
142. In FY16 NMSH's total expenditures were $8,216,510.
143. In FY17 NMSH had 50 beds.
144. In FY17 NMSH served 619 individuals.
145. In 2017 NMSH's average daily census was 48 individuals.
146. In 2017 NMSH's average length of stay was 33 days.
147. In FY17 NMSH's total expenditures were $7,612,841.
148. In FY18 NMSH had 50 beds.
149. In FY18 NMSH served 541 individuals.
150. In 2018 NMSH's average daily census was 46 individuals.
151. In 2018 NMSH's average length of stay was 39 days.

South Mississippi State Hospital

152. The South Mississippi State Hospital opened in Purvis in 2000.
153. In FY11 SMSH had 50 beds.
154. In FY11 SMSH served 546 individuals.
155. In FY11 SMSH's average daily census was 49 individuals.
156. In FY11 SMSH's average length of stay was 27 days.
157. SMSH reported that in FY11 SMSH's total expenditures were $7,896,965.
158. In FY12 SMSH had 50 beds.
159. In FY12 SMSH served 697 individuals.
160. In FY12 SMSH's average daily census was 46 individuals.
161. In FY12 SMSH's average length of stay was 22 days.
162. In FY13 SMSH had 50 beds.
163. In FY13 SMSH served 603 individuals.
164. In FY13 SMSH's average daily census was 45 individuals.
165. In FY13 SMSH's average length of stay was 25 days.
166. In FY14 SMSH had 50 beds.
167. In FY14 SMSH served 632 individuals.
168. In FY14 SMSH's average daily census was 45 individuals.
169. In FY14 SMSH's average length of stay was 25 days.
170. In FY15 SMSH had 50 beds.
171. In FY15 SMSH served 648 individuals.
172. In FY15 SMSH's average daily census was 43 individuals.
173. In FY15 SMSH's average length of stay was 27 days.
174. In FY16 SMSH had 50 beds.
175. In FY16 SMSH served 693 individuals.
176. In FY16 SMSH's average daily census was 46 individuals.
177. In FY16 SMSH's average length of stay was 22 days.
178. In FY17 SMSH had 50 beds.
179. In FY17 SMSH served 593 individuals.
180. In FY17 SMSH's average daily census was 43 individuals.

181. In FY17 SMSH's average length of stay was 24 days.
182. In FY18 SMSH had 50 beds.
183. In FY18 SMSH served 522 individuals.
184. In FY18 SMSH's average daily census was 45 individuals.
185. In FY18 SMSH's average length of stay was 28 days.

Central Mississippi Residential Center

186. The State operates the Central Mississippi Residential Center (CMRC) in Newton, MS. The CMRC has four residences with six bedrooms each. The residences are staffed. The CMRC also has twelve double-occupancy residences.
187. The CMRC also operates the Kemper County Group Homes ("KCGH"). KCGH consists of three residences with six bedrooms each. The KCGHs are staffed.
188. Both CMRC and KCGH are operated by EMSH and serve people with mental illness.

Programs of Assertive Community Treatment (PACT)

189. PACT is an individual-centered, recovery-oriented mental health service that facilitates community living and recovery for persons with the most severe and persistent mental illness who have severe symptoms and impairments and have not benefited from traditional outpatient services.
190. PACT is for individuals with indicators of continuous high-service needs, including high use of psychiatric hospitals or psychiatric emergency services, significant difficulty meeting basic survival needs, and difficulty utilizing traditional office-based outpatient services.
191. PACT is delivered by a mobile interdisciplinary team of mental health professionals, including a psychiatrist or psychiatric nurse practitioner, registered nurses, a substance abuse specialist, an employment specialist, and a peer specialist.
192. PACT services are delivered on an ongoing basis in a manner that emphasizes relationship building and active involvement.
193. DMH standards call for PACT teams to have the capacity to provide multiple contacts each week. Contacts can be as frequent as 2-3 times per day, 7 days per week depending on the person's need. PACT teams have the ability to rapidly increase service activity as necessary for the individual.
194. As of June 30, 2018, the State had eight PACT teams in operation.
195. As of June 30, 2018, the teams operating in the following counties and were established at the following times.
    a. Grenada, Leflore, & Holmes: June 2010
    b. Warren, Yazoo: April 2011
    c. Lamar, Forrest: December 2014
    d. Hancock, Harrison, Jackson: December 2014
    e. Hinds: February 2015
    f. DeSoto: March 2015
    g. Lee: June 2015
    h. Lauderdale: June 2015

196. In FY17 there were 140 admissions to PACT teams.
197. In FY16 the PACT teams served a total of 248 individuals.
198. In FY16 there were 85 admissions to PACT teams.
199. In FY 15, the State served only 189 people with PACT, despite the overwhelming need for the service.
200. In FY15 there were 97 admissions to PACT teams.
201. Under DMH's standards for the operation of PACT teams, if the eight existing PACT teams had the minimum number and type of staff required by DMH's operational standards, they could each serve 80 individuals. Thus, the eight existing teams could serve a minimum of 640 individuals, while maintaining a ratio of one staff for every ten clients.
202. PACT teams receive grant funding from DMH.
203. In FY15 DMH provided grants of $600,000.00 per PACT team.
204. In FY16 DMH provided grants of $600,000.00 per PACT team.
205. In FY17 DMH provided grants of $600,000.00 per PACT team.
206. PACT is a service reimbursable through Mississippi Medicaid.

Mobile Crisis

207. Mobile Crisis Response Services are designed to deliver solution-focused and recovery-oriented behavioral health assessments and stabilization of crisis in the location where the individual is experiencing the crisis. Without Crisis Response intervention, the individual experiencing the crisis may be inappropriately and unnecessarily placed in a jail, holding facility, hospital or inpatient treatment facility.
208. All fourteen CMHC regions established Mobile Crisis Response Teams in 2014.
209. Mobile crisis response services are required by DMH regulation to be available 24 hours a day, 7 days a week, 365 days a year.
210. The data in MS-145564, a database related to the Mobile Crisis Response Teams, reflects utilization of the Mobile Crisis Response Teams, as reported to DMH.
211. Mobile crisis is a service reimbursable through Mississippi Medicaid.

Crisis Stabilization Units ("CSUs")

212. CSUs provide psychiatric supervision, nursing, therapy, and psychotherapy to individuals experiencing psychiatric crises, and are designed to prevent civil commitment and/or longer-term inpatient hospitalization by addressing acute symptoms, distress, and further decompensation.
213. CSUs in Mississippi have an average length of stay of 10.71 days.
214. CSUs in Mississippi take voluntary and involuntary admissions.
215. In FY11 CSUs in Mississippi served 3,060 individuals.
216. In FY12 CSUs in Mississippi served 3,767 individuals.
217. In FY13 CSUs in Mississippi served 3,731 individuals.
218. In FY14 CSUs in Mississippi served 4,007 individuals: 2,174 voluntary and 1,833 involuntary.

219. In FY15 CSUs in Mississippi served 3,609 individuals: 1,988 voluntary and 1,621 involuntary.
220. In FY16 CSUs in Mississippi served 3,270 individuals: 1,732 voluntary and 1,538 involuntary.
221. In FY17 CSUs in Mississippi served 3,129 individuals: 1,795 voluntary and 1,328 involuntary.
222. As of June 30, 2018, there were eight CSUs in the State.
    a. As of June 30, 2018, the CSUs were in the following locations, and were in operation since at least 2011. Batesville (Region 4)
    b. Brookhaven (Region 8)
    c. Cleveland (Region 6)
    d. Corinth (Region 4)
    e. Grenada (Region 6)
    f. Gulfport (Region 13)
    g. Laurel (Region 12)
    h. Newton (Region 10)
223. In FY15 DMH provided grants of on average $1,435,000.00 per CSU.
224. In FY16 DMH provided grants of on average $1,402,375.00 per CSU.
225. In FY17 DMH provided grants of on average $1,402,375.00 per CSU.
226. Crisis stabilization is a service reimbursable through Mississippi Medicaid under the crisis residential definition.

Supported Employment for People with Serious Mental Illness (SMI)

227. Supported Employment for SMI assists individuals with severe and persistent mental illness in obtaining and maintaining competitive employment.
228. Supported Employment for SMI helps individuals achieve and sustain recovery.
229. Beginning in January 2015, the State has provided funding to four pilot sites to provide supported employment to people with mental illness as of the end of FY18.
230. In FY15 22 individuals with SMI received supported employment.
231. In FY16 108 individuals with SMI received supported employment.
232. In FY17 116 individuals with SMI received supported employment.
233. In FY16 DMH provided each pilot site with a $100,000 grant.
234. In FY17 DMH provided each pilot site with a $100,000 grant.

CHOICE

235. According to SAMHSA, Permanent Supported Housing is an evidence-based practice that provides an integrated, community-based alternative to hospitals, nursing facilities, and other segregated settings. It includes housing where tenants have a private and secure place to make their home, just like other members of the community, and the mental health support services necessary to maintain the housing.
236. The State, through the Mississippi Home Corporation ("MHC"), and in partnership with DMH, operates a supported housing program called CHOICE that targets,

among others, individuals being discharged from State Hospitals and those who have history of multiple hospital visits in the last year due to mental illness.

237. CHOICE recipients receive mental health services from the local CMHC or other providers and are eligible for a rental subsidy administrated through MHC.
238. MHC contracts with Mississippi United to End Homelessness ("MUTEH") and Open Doors Homeless Coalition ("Open Doors") to provide housing placement and support services.
239. Individuals may be referred to CHOICE through a variety of sources, including the State Hospitals.
240. Although CHOICE is a statewide program, as of 2018 CHOICE had been used in only approximately half of the counties in the State.
241. The rental subsidy available through CHOICE is intended to serve as a bridge subsidy and thus is available to an individual for one year, but can be extended for three additional months. The goal of the program is for the individual receiving support through CHOICE to gain self-sufficiency or to obtain long-term subsidized housing.
242. CHOICE was funded for the first time in 2015.
243. Ben Mokry testified that CHOICE began taking applications for program participants in February 2016.
244. Between 2015 and June 30, 2018, CHOICE was appropriated approximately $5.3 million and had drawn down approximately $2.4 million.
245. As of 2018, it cost approximately $8,000 per person per year to provide a supported housing through CHOICE.
246. In 2015 the State set a goal of serving 200 people through CHOICE.
247. In 2015 Ben Mokry believed it needed 2,500 housing units to meet the need for supported housing in certain regions of the state.
248. In FY16 48 individuals were served through CHOICE.
249. In FY17 205 individuals were served through CHOICE.
250. Between 2015 and June 30, 2018, CHOICE had provided supported housing to a total of 345 individuals at some point in time.

Peer Supports

251. Peer Supports are provided in Mississippi by Certified Peer Support Specialists ("CPSS"), individuals or family members of individuals who have received mental health services and have received training and certification from the State.
252. CPSS may work in State Hospitals, as part of PACT or Mobile Crisis Response Teams, for CMHCs, or for other providers and serve as a resource for individuals with mental illness. Peer specialists engage in person-centered activities with a rehabilitation and resiliency/recovery focus. These activities allow consumers of mental health services and their family members the opportunity to build skills for coping with and managing psychiatric symptoms and challenges associated with various disabilities while directing their own recovery.
253. As of June 30, 2018, there were 230 CPSS in the State.
254. In FY17 there were 159 CPSS in the State.

255. In FY16 there were 161 CPSS in the State.
256. In FY15 there were 141 CPSS in the State.
257. In FY14 there were 80 CPSS in the State.
258. In FY13 there were 66 CPSS in the State.

The Division of Medicaid

259. The Division of Medicaid has design, administration, and oversight responsibilities for Mississippi's Medicaid Program.
260. The Division of Medicaid drafts the State's Administrative Code for Medicaid and develops amendments to the State Medicaid Plan.
261. The Administrative Code sets parameters that providers and managed care organizations use to determine whether services are medically necessary and reimbursable through Medicaid.
262. States that participate in the Medicaid program, must adhere to federal Medicaid rules and regulations.
263. For Medicaid, the Federal Medical Assistance Percentage (FMAP) is used to calculate the amount of federal matching funds for state medical services expenditures.
264. In FY2017 the FMAP for Mississippi was 74.63, meaning that the federal government contributed about 3 dollars for every one dollar Mississippi spent on eligible services.
265. Federal Medicaid regulations require services available through the Medicaid State Plan to be available statewide.
266. Crisis residential (CSU), crisis response (mobile crisis), community support services, targeted case management, Assertive Community Treatment (PACT), psychotherapy, psychiatric diagnostic evaluation, evaluation and management, and peer support are among the services included in the Mississippi Medicaid State Plan. The full list of services is found at https://medical.ms.gov/providers/fee-schedules-and-rates/#.
267. In Mississippi, Medicaid is provided through a fee-for-service program operated by the Division of Medicaid and through a managed care program operated by three managed care organizations (MCOs).
268. In the fee-for-service program, the Division of Medicaid directly contracts with providers who meet the requisite qualifications set by the Division of Medicaid and reimburses providers for medically necessary services available under the State Medicaid Plan.
269. For fee-for-service Medicaid recipients in Mississippi, the Division of Medicaid has placed limits on the amount of certain services available to Medicaid participants in a given year.
270. Division of Medicaid publishes a fee schedule each year for community mental health services provided in a community mental health center/private mental health center that governs the rates for mental health services provided in the fee-for-service Medicaid system. The full list of services is found at https://medical.ms.gov/providers/fee-schedules-and-rates/#.

271. Three managed care organizations (MCOs) currently operate in Mississippi: United (also known as Optum), Magnolia (also known as Cenpatico), and Molina.
272. Molina began operating in October 2018.
273. The MCOs receive a capitated rate from DOM for each member each month irrespective of the actual cost of the services that they provide that month.
274. The MCOs pay providers a rate for each service that is equal to or greater than the rate paid by DOM to the CMHCs and other providers for the same service in the fee-for-service system.
275. The MCOs are not required to implement the service limits that the Division of Medicaid has implemented in the fee-for-service program.
276. The Mississippi DOM retains oversight responsibility for the MCOs with which it contracts.
277. According to Ted Lutterman, in FY17, Mississippi reported that 71% of people receiving services through DMH had at least some of those services funded by Medicaid.
278. Division of Medicaid and Department of Mental Health entered an agreement to process Medicaid enrollment or reenrollment for people upon discharge from a State Hospital in 2018.
279. In Mississippi, people who qualify for Supplemental Security Income due to a disability, such as mental illness, are eligible for Medicaid.
280. Individuals in Mississippi who gain Medicaid eligibility because they also have Supplemental Security Income (SSI) are required to participate in the managed care program.

PACT

281. Robert Drake recommended that 1 of the 7 individuals he reviewed in his Expert Report in this case is appropriate for and would benefit from PACT. (Robert Drake's Expert Report).
282. Daniel Byrne recommended that 19 of the 33 living individuals he reviewed in his Expert Report in this case are appropriate for and would benefit from PACT. (Daniel Byrne's Expert Report and Depo. Exh. D-11).
283. Judith Baldwin recommended that 19 of the 30 living individuals she reviewed in her Expert Report in this case are appropriate for and would benefit from PACT. (Judith Baldwin's Expert Report and Depo. Exh. D-57).
284. Katherine Burson recommended that 20 of the 28 individuals she reviewed in her Expert Report in this case are appropriate for and would benefit from PACT. (Katherine Burson's Expert Report and Depo. Exh. D-66).
285. Beverley Bell-Shambley recommended that 19 of the 25 living individuals she reviewed in her Expert Report in this case are appropriate for and would benefit from PACT. (Beverley Bell-Shambley's Expert Report).
286. Carol VanderZwaag recommended that 22 of the 27 living individuals she reviewed in her Expert Report in this case are appropriate for and would benefit from PACT. (Carol VanderZwaag's Expert Report and Depo. Exh. D-31).

Housing

287. The recommendations of the United States' Clinical Review Team regarding housing are accurately summarized on Exhibit 1 to this Stipulation.

ISMICC and ISMICC Report dated December 13, 2017

288. The ISMICC Report states that the 21st Century Cures Act authorizes the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC) to enhance coordination across federal agencies to improve service access and delivery of care for people with serious mental illness (SMI) and their families. (ISMICC Report at 2).
289. The ISMICC is chaired by Dr. Elinore F. McCance-Katz, Assistant Secretary for Mental Health Substance Use. (ISMICC Report at 3).
290. The ISMICC Report states that the ISMICC is a historic chance to address SMI across federal departments. (ISMICC Report at 3).
291. The following federal departments and agencies are represented on the ISMICC:
    - Secretary of the Department of Health and Human Services.
    - Assistance Secretary for Mental Health and Substance Use.
    - Attorney General, Department of Justice.
    - Secretary of the Department of Veterans Affairs.
    - Secretary of the Department of Defense.
    - Secretary of the Department of Housing and Urban Development.
    - Secretary of the Department of Education.
    - Secretary of the Department of Labor.
    - Administrator of the Centers for Medicare and Medicaid Services.
    - Commissioner of the Social Security Administration.

(ISMICC Report at 3).

292. Each of the eight federal departments on the ISMICC supports programs that address the needs of people with SMI. (ISMICC Report at 3).
293. The ISMICC Report states that the collaboration between the eight departments will be informed and strengthened by the participation of non-federal members, including national experts on health care research, mental health providers, advocates, and people with mental health conditions and their families and caregivers. (ISMICC Report at 3).
294. The ISMICC identified the following five major areas of focus:
    - Strengthen federal coordination to improve care.
    - Access and engagement: Make it easier to get good care.
    - Treatment and recovery: Close the gap between what works and what is offered.

- Increase opportunities for diversion and improve care for people with SMI and SED involved in the criminal and juvenile justice systems.
- Develop finance strategies to increase availability and affordability of care.

(ISMICC Report at 4).

295. The ISMICC Report states that the non-federal ISMICC members have firsthand experience with the mental health service system, and knowledge of what barriers exist for people who are seeking help. The Report further states that the non-federal members bring on-the-ground solutions and innovative ideas that can promote change and improve lives, in partnership with the federal members. (ISMICC Report at 3).
296. The ISMICC Report states that in 2003, the President's New Freedom Commission on Mental Health concluded that America's mental health service delivery system was in shambles. According to the ISMICC Report, the Commission's final report stated that "for too many Americans with mental illnesses, the mental health services and supports they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery." (ISMICC Report at 1).
297. The ISMICC Report states that a number of the recommendations of the President's New Freedom Commission on Mental Health were not implemented or have only been partially realized. According to the ISMICC Report, since then the quality of life has not fundamentally changed for adults with serious mental illness (SMI). (ISMICC Report at 1).
298. The ISMICC Report states that about 1 in 25 adults has an SMI in a given year. (ISMICC Report at 11).
299. The ISMICC Report states that adults with SMI often have chronic conditions and general health issues. (ISMICC Report at 12).
300. The ISMICC Report states that nearly three-quarters of adults with SMI are diagnosed with two or more mental disorders. (ISMICC Report at 12).
301. According to the Center for Behavioral Health Statistics and Quality (CBHSQ), about a quarter of adults with SMI (25.4 %,an estimated 2.6 million adults) have a substance use disorder, and approximately one in six (16.1%) misused opioids in the past year . (ISMICC Report at 12-13).
302. The ISMICC Report states that adults with SMI and substance use disorders "show more severe symptoms of mental illness, more frequent hospitalizations, more frequent relapses, and a poorer course of illness than patients with a single diagnosis, as well as higher rates of violence, suicide and homelessness." (ISMICC Report at 13).
303. The ISMICC Report states that relatively few adults with SMI receive effective treatments. (ISMICC Report at 13).
304. According to the CBHSQ, nearly a third (32.6%, 2.2 million adults) of those adults with SMI who get treatment receive medications only, with no psychosocial or psychotherapeutic services. (ISMICC Report at 13).
305. According to SAMHSA, adults with co-occurring SMI and substance use disorders, nearly two-thirds (63.2%) received mental health care, but only 14.3% received specialized substance use treatment. (ISMICC Report at 13).
306. The ISMICC Report states that effective treatment models for treating adults with SMI exist, but are not widely available. According to the ISMICC Report, states

report annually on the implementation of select evidence-based practices (EBPs) in their systems. (ISMICC Report at 15).

307. The ISMICC Report states that state mental health systems often serve those with mental health conditions, including SMI, who are Medicaid eligible and whose conditions require levels of care not paid for by private insurance. (ISMICC Report at 15).

308. The ISMICC Report states that the percentage of the population who have access to these EBPs remains low and varies widely across states, recognizing that not all EBPs are appropriate for all people with SMI. (ISMICC Report at 15).

309. The ISMICC Report states that assertive community treatment, an intensive team-based care model that is a long-established best practice for adults with SMI, is provided to only 2.1% of the people served in state systems nationwide, based on only a subset of states that provided this data. (ISMICC Report at 15).

310. The ISMICC Report states that the individual placement and support model of supported employment, which should be provided to all adults with SMI who have a goal of employment also is provided to only 2.1% of adults and transition-age youth with SMI in state systems, based on only a subset of states that provided this data. (ISMICC Report at 15).

311. The ISMICC Report states that most counties in the United States face shortages of mental health professionals. (ISMICC Report at 15).

312. The ISMICC Report states that in 96% of the counties in the nation, there is a shortage of psychiatrists who prescribe medications for people with SMI. (ISMICC Report at 15).

313. The ISMICC Report states that from 2003 to 2013, the number of practicing psychiatrists decreased by 10% when adjusted for population size. (ISMICC Report at 15).

314. The ISMICC Report states that many psychiatrists are shifting to private practice, accepting only cash for reimbursement. The Report continues, stating that in part, this may reflect low reimbursement for psychiatric services from state Medicaid program and Medicaid-contracted managed care payers, cuts to federal and state funding for public sector programs, and inadequate rate setting for psychiatric services. (ISMICC Report at 15-16).

315. The ISMICC Report states that the greatest shortages of psychiatrists are in poor and more rural areas. (ISMICC Report at 16).

316. The ISMICC Report states that most states report insufficient psychiatric crisis response capacity as well as insufficient numbers of inpatient psychiatric hospital beds. (ISMICC Report at 16).

317. The ISMICC Report states that it is critical that every state have adequate bed capacity to respond to the needs of people experiencing both psychiatric crises and those who are in need of longer inpatient care, such as people in forensic care. (ISMICC Report at 16).

318. The ISMICC Report states that a report by the National Association of State Mental Health Program Directors Research Institute found that most states (35 of 46 who responded) have shortages of psychiatric hospital beds. (ISMICC Report at 16).

319. The ISMICC Report states that the configuration of available psychiatric hospital beds and the number of psychiatric hospital beds per 100,000 population varies

substantially across states, but few states report they have adequate numbers of psychiatric inpatient beds to meet needs. (ISMICC Report at 16).

320. The ISMICC Report states that adults with SMI are more likely to be jailed or involved with the criminal justice system. (ISMICC Report at 17).
321. The ISMICC Report states that it is estimated that approximately two million people with SMI are admitted annually to U.S. jails. (ISMICC Report at 17).
322. The ISMICC Report states that among these admissions of people with SMI to U.S. jails, 72% also meet criteria for co-occurring substance use disorders. (ISMICC Report at 17).
323. The ISMICC Report states that specialty courts for people with mental or substance use disorders are promising, but their availability is extremely limited. (ISMICC Report at 17).
324. The ISMICC Report states that nearly twice as many adults with SMI have incomes below the poverty level as in the general population (22.8%, compared to 13.5%). (ISMICC Report at 17).
325. The ISMICC Report states that SMI is common among people experiencing homelessness. (ISMICC Report at 17).
326. The ISMICC Report states that HUD and SAMHSA estimate that about one in five people (nearly 108,000 people) experiencing homelessness has an SMI, and a similar percentage have a chronic substance use disorder. (ISMICC Report at 17).
327. The Office of National Drug Control Policy reports that approximately 30% of people who are chronically homeless live with an SMI. (ISMICC Report at 17).
328. The ISMICC Report states that mental illnesses lead to high medical costs. (ISMICC Report at 18).
329. The ISMICC Report states that health care costs are increased by two or three times for people with mental illness, even if their conditions are not among the most serious. (ISMICC Report at 18).
330. The ISMICC Report states that national data on the treatment gap – the difficulty of people accessing care- reveals that 50 to 90% of those in need of mental health treatment are not receiving services. (ISMICC Report at 54).
331. The ISMICC Report states that most people with SMI have approximately three or four behavioral health disorders and three or four physical health disorders. The Report further states that people with SMI often have deficits in memory, concentration, executive functioning, and ability to organize information. (ISMICC Report at 56).
332. The ISMICC Report states that in terms of availability of treatment and services for people with SMI the psychiatry shortage is particularly severe. The ISMICC Report further states that reports indicate a shortage of available psychiatric treatment, with hospitals closing beds or not providing care due to financial loss. (ISMICC Report at 56).
333. The ISMICC Report states that over the next five years, the ISMICC will work in collaboration with federal interdepartmental leadership to build shared accountability for a system that provides the full range of treatments and supports needed by individuals and families living with SMI. (ISMICC Report at 61).
334. The ISMICC Report states that ISMICC members recognize that this collaborative effort over the next five years will require partnerships with all levels of government

and a diverse array of other stakeholders. The Report further states that mental health care is not solely a federal responsibility, but rather one shared across federal, state, tribal, and local governments; private insurers; diverse provider organizations; advocates; caregivers; families; and people with SMI. (ISMICC Report at 61).

335. The ISMICC Report states that as the ISMICC undertakes the challenging work of evaluating and recommending ways to strengthen federal policies and programs, a key goal will be to ensure that changes made at the federal level actually lead to better lives for people with SMI throughout the nation. There are many sources of funding for mental health and substance use disorder treatment, including federal and state governments, private insurance, individuals who pay for services directly, and other private sources. (ISMICC Report at 63).

336. The ISMICC Report states that making the policies and programs of Medicare more effective at addressing the needs of people with SMI could have widespread benefits,. (ISMICC Report at 64).

337. The ISMICC Report states that a deeper examination of federal programs should attempt to answer common evaluation questions such as: Do current policies and programs have sufficient reach to serve all of the people with SMI who could benefit? The ISMICC Report further states that a concern is that federal programs may be designed, accidentally or intentionally, to restrict the number of people who can participate and consequently exclude vulnerable populations or those with limited access such as people in rural areas. (ISMICC Report at 66-67).

338. The ISMICC Report states that programs designed to restrict the number of people who can participate may occur inadvertently through the construction of program eligibility criteria that fail to acknowledge all relevant circumstances. (ISMICC Report at 67).

339. The ISMICC Report states that programs designed to restrict the number of people who can participate also may occur simply as the result of inadequate funding – a universally important consideration that may be difficult to address. (ISMICC Report at 67).

340. The ISMICC Report states that a key concern of ISMICC will be how to ensure that improvements developed at the federal level are implemented comprehensively throughout the states, tribes, and localities across the nation. (ISMICC Report at 69).

341. The ISMICC Report states that there are complex and multilayered federal, state, and local funding streams that support services needed by the SMI population. (ISMICC Report at 69).

342. Chapter 4 of the ISMICC Report contains recommendations developed solely by the non-federal members of the ISMICC, which reflect the hope of the non-federal members that federal departments will better align and coordinate their efforts to support people with SMI. These recommendations do not represent federal policy, and the federal departments represented on the ISMICC have not reviewed the recommendations to determine what role they could play in the future activities of the departments. The recommendations should not be interpreted as recommendations from the federal government. (ISMICC Report at 77).

343. The ISMICC Report States that the carefully selected set of recommendations of the non-federal members of the ISMICC were chosen to provide critical points of deliberation within the ISMICC. (ISMICC Report at 77).

344. Recommendations of the non-federal members of the ISMICC, as stated in the ISMICC Report, include::

- Improve ongoing interdepartmental coordination under the guidance of the Assistant Secretary for Mental Health and Substance Use. (ISMICC Report at 78).
- Harmonize and Improve policies to support federal coordination...Activities include but are not limited to: (b) identifying federal and other barriers across federal departments that preclude or impede access to services, treatments, or continuity of care. (ISMICC Report at 79).
- Evaluate the federal approach to servicing people with SMI. Evaluate systems, services, and supports for people with SMI, and assess effectiveness. Routinely measure, evaluate, and improve the federal government's efforts. Identify areas where the federal government is failing to meet the needs of people with SMI. Support evaluation and accountability for individual federal programs. See how federal programs fit within the larger support system. Identify and reduce non-coordinated duplications across departments. (ISMICC Report at 80).
- Define and implement a national standard for crisis care. (ISMICC Report at 81).
- Develop a continuum of care that includes adequate psychiatric bed capacity and community-based alternatives to hospitalization. (ISMICC Report at 81).
- Maximize the capacity of the behavioral health workforce. Through federal interdepartmental planning, find ways to increase the capacity of the behavioral health workforce to meet the needs of people with SMI and their families. (ISMICC Report at 82)
- Provide a comprehensive continuum of care for people with SMI. (ISMICC Report at 84).
- Make housing more readily available for people with SMI. Housing is an essential prerequisite for effective treatment and a life in recovery. Develop consistent federal policies to support and require adequate housing as a standard part of recovery-oriented treatment for people with SMI...Have HUD issue guidance for state and local housing authorities on establishing tenant selection preferences for non-elderly people with SMI, consistent with federal fair housing requirements. Target resources such as Housing Choice Vouchers for individuals with SMI experiencing chronic homelessness or transitioning from settings such as correctional facilities, nursing homes, or board and care homes. (ISMICC Report at 86).
- Develop national and state capacity to disseminate and support implementation of the national standards for a comprehensive continuum of effective care for people with SMI. The challenges of implementation are well known, but rarely adequately addressed. As a consequence, we, the non-federal members, find a

huge gap between what is known to be effective and what is available in communities throughout the nation. (ISMICC Report at 87).

- Adequately fund the full range of services needed by people with SMI. Federal health benefit programs (including Medicaid, Medicare, VA, and TRICARE) should cover outreach services, bidirectional integration of physical and behavioral health care, care coordination, consultation, supported housing and employment services, family and peer support services, and other services needed by people with SMI. Payment models should make it easy to reimburse providers for services. Fund such services directly or through models such as health homes, accountable care organizations, and managed care organizations. Federal departments should partner with private health plans, and with state and local governments, to promote similar approaches. (ISMICC Report at 90).
- Eliminate financing practices and policies that discriminate against behavioral health care. Identify and eliminate programs, practices, and policies that make it hard to deliver good mental health care. This includes ending the exclusion for reimbursement of services to adults under age 65 in Institutions for Mental Diseases. (ISMICC Report at 91).
- Medicare, Medicaid, and other benefit programs should provide adequate reimbursement for the full range of services needed by people with SMI, at rates equivalent to rates for other types of health care services. (ISMICC Report at 91).

345. On August 31, 2017, Dr. Thomas E. Price, M.D., then Secretary of Health and Human Services, at the first meeting of the ISMICC, stated the following: "We replaced an imperfect and sometimes cruel system of institutionalization with a system that is in many cases even more cruel – and failed to equip families and healthcare providers with what they need to fix it." (HHS.gov Transcript).

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